DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1154 (03/01)

STAT-PA ORTHOPEDIC SHOES WORKSHEET

Recipient's Name _____

Prior Authorization (PA) Number ____ ____ ____ ____ ____ ____ ____
The STAT-PA system will indicate the seven-digit PA number at the end of the transaction. Please record the number here.

REMINDER: *The STAT-PA Orthopedic Shoes Worksheet is a required worksheet for documenting the information needed to request PA for orthopedic shoes. The provider is required to enter all information from each category in the spaces provided. The STAT-PA system will ask for the following items in the order listed below:*

STAT-PA REQUIRED INFORMATION

Provider Number ____ ____ ____ ____ ____ ____ ____ ____
Enter your eight-digit Medicaid provider number.

Recipient Medicaid Identification Number ____ ____ ____ ____ ____ ____ ____ ____ ____ ____
Enter the recipient's ten-digit Medicaid ID number. This can be found on the Medicaid Forward ID card.

Procedure Code of Product Requested ____ ____ ____ ____ ____
Enter *one* requested procedure code per STAT-PA request.
For touch-tone telephone users, the code will be entered as follows:
L3216 = *53 3 2 1 6 L3221 = *53 3 2 2 1 A5500 = *21 5 5 0 0

Type of Service ____
For touch-tone telephone users, type of service "P" should be entered as "*71"

Diagnosis Code _____
Use the recipient's *International Classification of Diseases, Ninth Revision, Clinical Modification* [ICD-9-CM] three- to six-digit diagnosis code. The decimal point for diagnosis codes is not required; however, all digits of the code must be entered.

Place of Service ____
Place of service for orthopedic shoes may be 3 (Office), 4 (Home), 7 (Nursing Home), or 8 (Skilled Nursing Facility).

Requested Grant Date or Date of Service ____ ____ ____ ____ ____ ____ ____ ____
Use the eight-digit format MMDDCCYY. The grant date entered may be up to 31 calendar days in the future. In the event that the STAT-PA system is unavailable at the time the shoes are provided, the PA request may be backdated up to four calendar days.

Quantity or Days Supply Requested ____

STAT-PA REQUEST CHECKLIST

ALL information must be entered for each category, both in the STAT-PA system and on this worksheet.

A. Please enter the eight-digit signature date on the prescription in MMDDCCYY format. The prescription date cannot be more than six months in the past from the requested grant date.

___ ___ ___ ___ ___ ___ ___ ___

B. Has the recipient received orthopedic shoes in the past?

If yes, enter 1. If no, enter 2. ____

1. If yes, proceed to question C.
2. If no, proceed to question E.

C. Did the recipient wear orthopedic shoes to the pedorthic examination?

If yes, enter 1. If no, enter 2. ____

1. If yes, proceed to question D.
2. If no, you will receive the following message: "Your prior authorization request requires additional information. Please submit your request on paper with complete clinical documentation."

D. Are the recipient's current shoes in disrepair?

If yes, enter 1. If no, enter 2. ____

1. If yes, proceed to question E.
2. If no, you will receive the following message: "Your prior authorization request requires additional information. Please submit your request on paper with complete clinical documentation."

E. Are the requested shoes manufactured by Drew, P.W. Minor, Markell, or Apex?

If yes, enter 1. If no, enter 2. ____

1. If yes, proceed to the next step.
2. If no, you will receive the following message: "Your prior authorization request requires additional information. Please submit your request on paper with complete clinical documentation."

F. Please enter the Mobility Level (MBL) that best describes the recipient. ____

MBL 1 - The recipient walks in the community with or without the assistance of another person or an assistive device. (Enter 1)

MBL 2 - The recipient walks in his/her place of residence only with or without the assistance of another person or an assistive device. (Enter 2)

MBL 3 - The recipient does not stand up to walk or transfer without maximum assistance or mechanical support. (Enter 3)

G. Please enter the Diagnosis Level (DXL) that best describes the recipient. ____

DXL 1 - The recipient has urinary incontinence or any underlying pathology that results in a flat foot. (Enter 1)

DXL 2 - The recipient has diabetes with complications such as: gross foot deformity, excluding diagnosis code 250.0, history of foot ulcers, loss of sensation, etc. (Enter 2)

DXL 3 - The recipient has gross foot deformity(ies). (Enter 3)

DXL 4 - The recipient has a chronic disorder or disability, without gross foot deformity, such as: osteoarthritis, rheumatoid arthritis, cerebral palsy, mental retardation, cerebral vascular accident, peripheral, vascular disease, cardiovascular disease, diabetes without complications, plantar faciitis, Alzheimer's disease, senile dementia, multiple sclerosis, Parkinson's disease, etc. (Enter 4)

H. Please enter the recipient's nine-digit Need Level (NDL) number. (Use 1 to indicate a "yes" response to the need level or 2 to indicate a "no" response to the need level.)

Need Level (NDL)	**Response Yes = 1 No = 2**
NDL 1 - Are the extra depth shoes necessary for arch supports to treat flat feet?	
NDL 2 - Do extra depth shoes require replacement due to soiling from urine?	
NDL 3 - Are extra depth shoes necessary to accommodate shoe inserts that will support an orthopedic deformity (other than those in NDL 1)?	
NDL 4 - Are extra depth shoes necessary to accommodate AFO/KAFO (other than those in NDL 1)?	
NDL 5 - Does the recipient have a leg length discrepancy equal to or greater than 1/2 inch?	
NDL 6 - Are extra depth shoes necessary to provide support for the recipient's gross foot deformity?	
NDL 7 - Will the recipient maintain his/her Mobility Level (MBL) if orthopedic shoes are provided?	
NDL 8 - Can the recipient improve at least one full MBL if orthopedic shoes are provided?	
NDL 9 - Are mismate shoes equal to, or greater than, one full size necessary?	

Please enter all nine digits of the Need Level: ___ ___ ___ ___ ___ ___ ___ ___ ___

A PA number will be assigned at the end of the transaction. Please enter the assigned PA number in the space provided at the top of the first page of this worksheet, below the recipient's name.

Reset Form